PRINTED: 09/30/2008 FORM APPROVED

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			BER:			(X3) DATE SURVEY COMPLETED - 08/27/2008		
NVN2521AG0		NIVNISESTA CC	A. BUILDING B. WING					
				_ RESS, CITY, STA	TE, ZIP CODE	00/2	27/2006	
BEE HIVE HOMES LLC				1683 WINCHESTER DR ELKO, NV 89801				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
Y 000	Initial Comments			Y 000				
	This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility 8/26-27/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and seven employee files were reviewed.							
	The following deficiencies were identified:							
Y 070 SS=D	070 449.196(1)(f) Qualifications of Caregiver-8 hotel training		ours	Y 070				
NAC 449.196 1. A caregiver of a refacility must: (f) Receive annually rhours of training relatfor the needs of the residential facility.		not less than 8 ted to providing						
	Based on record revi	ot met as evidenced by ew from 8/26/08 to 8/27 sure evidence of at leas training related to provesidents for 1 of 7	7/08, st					
	Findings include:							
	trainings with start tin 2008. There was no	entained a list of seven nes from July 2007 to J evidence of the length employee had complete	of the					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2521AGC 08/27/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1683 WINCHESTER DR **BEE HIVE HOMES LLC** ELKO. NV 89801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 070 Continued From page 1 Y 070 them. Severity: 2 Scope: 1 Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=F re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication

at least three hours of medication re-training. Findings include:

This Regulation is not met as evidenced by: Based on record review on 8/27/08, the facility did not ensure 3 of 3 caregivers had evidence of

approved by the Bureau.

Employees #3, #5 and #7 all completed three hours of medication re-training on 8/3/05. There was no evidence in their files of at least three hours of medication re-training by August of 2008.

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2521AGC 08/27/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1683 WINCHESTER DR **BEE HIVE HOMES LLC** ELKO. NV 89801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 072 Y 072 Continued From page 2 Severity: 2 Scope: 3 Y 105 449.200(1)(f) Personnel File - Background Check Y 105 SS=D NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review from 8/26/08 to 8/27/08, the facility did not ensure that 1 of 7 employees met the background check requirements for criminal history. Findings include: The file for Employee #1, hired on 1/12/07, contained a background check report from the State of Nevada dated in November of 2007. There was not a report from the FBI.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Severity: 2 Scope: 1

NAC 449.200

449.200(2)(a) Personnel File - 1st aid & CPR

residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and

2. The personnel file for a caregiver of a

cardiopulmonary resuscitation.

Y 106

SS=D

Y 106

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2521AGC 08/27/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1683 WINCHESTER DR BEE HIVE HOMES LLC** ELKO, NV 89801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 106 Y 106 Continued From page 3 This Regulation is not met as evidenced by: Based on record review from 8/26/08 to 8/27/08, the facility did not ensure 1 of 7 caregivers had evidence of current first aid training. Findings include: Employee #2 - The employee's file contained a first aid card that expired in March of 2008. Severity: 2 Scope: 1 Y 178 449.209(5) Health and Sanitation-Maintain Int/Ext Y 178 SS=D NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Based on observation and interview on 8/27/08, the facility did not ensure its indoor ventilation system was appropriately maintained.

Two overhead air intake ducts were observed in the facility hallways. The metal grate covers had a thick layer of dust accumulated on them. The caregiver reported there was a lot of dust in the

Findings include:

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2521AGC 08/27/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1683 WINCHESTER DR BEE HIVE HOMES LLC** ELKO, NV 89801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 178 Continued From page 4 Y 178 air due to houses being constructed in their neighborhood. The caregiver also stated there were no air filters in the ducts to help trap the Severity: 2 Scope: 1